Magellan*
Grievance Form

GRIEVANCE FORM **IMPORTANT:** Can you read this in English? If not, we can have someone help you read it. For free help, please call your program toll-free number.**	**IMPORTANTE:** ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en español. Para obtener ayuda gratuita, llame al número gratuito de su programa.**

We are very interested in hearing your concerns. Please complete this form and mail it to us, or if you prefer, contact us at your program toll-free number.**

Name: _____ Date of Birth: _____
Address:_____
Street City State Zip Code_____
Home Phone: _____ Work Phone: _____
Health Plan or Sponsor (The organization through which you are receiving EAP or behavioral health services from Magellan*):
_____
May Magellan use your name in the investigation of this grievance? ☐ YES ☐ NO
May Magellan contact you by mail? ☐ YES ☐ NO
(Please note for State of CA residents, a written resolution letter is sent automatically.)
May Magellan contact you by telephone? ☐ YES --Phone #_____ ☐ NO
Would you like written notification acknowledging receipt of your grievance? ☐ YES ☐ NO
Would you like written notification of the outcome of your grievance? ☐ YES ☐ NO
Would you like verbal notification of the outcome of your grievance? ☐ YES ☐ NO
Special instructions for contacting you (for example, time of day, person with whom it is okay to leave messages, etc.):
_____
_____
Name of Provider: _____ Approximate date this provider was last seen: _____
Complaint: (Attach additional pages if needed)
_____
_____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800--424-1565**** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219**) and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Signature _____ Date _____

Please send completed form to :
Comment Coordinator, Magellan Employer Services
P.O. Box 710430, San Diego, California 92171

*Magellan subsidiaries in California are Human Affairs International of CA (HAI-CA), and Magellan Health Services of California, Inc.-Employer Services (Magellan Employer Services).
If you are speech or hearing impaired, call our toll free TTY number **1-800-456-4006 for assistance.